THE INSURANCE CODE OF 1956 (EXCERPT) Act 218 of 1956

500.3815 Outline of coverage; acknowledgment of receipt; compliance with notice requirements; substitute; language, format, and required items.

Sec. 3815. (1) An insurer that offers a medicare supplement policy shall provide to the applicant at the time of application an outline of coverage and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

- (a) A cover page.
- (b) Premium information.
- (c) Disclosure pages.
- (d) Charts displaying the features of each benefit plan offered by the insurer.
- (2) Insurers shall comply with any notice requirements of the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.
- (3) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and shall contain the following statement, in no less than 12-point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

(4) An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through L letter designation of the plan shall be shown on the cover page and the plans offered by the insurer shall be prominently identified. Premium information shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and method of payment mode shall be stated for all plans that are offered to the applicant. All possible premiums for the applicant shall be illustrated. The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the commissioner:

(Insurer Name) Medicare Supplement Coverage

Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)____[insert letter(s) of plan(s) being offered]
Medicare supplement insurance can be sold in only 12
standard plans plus 2 high deductible plans. This chart shows
the benefits included in each plan. Every insurer shall make
available Plan "A". Some plans may not be available in your

BASIC BENEFITS: For plans A-J.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

	A	В	С	D	E	F F*	G	H	I	J J*
Basic Benefits	х	х	х	х	х	х	х	х	х	х
Skilled Nursing										
Co-Insurance			х	х	х	х	х	х	х	х
Part A Deductible		х	х	х	х	х	х	х	х	х
Part B Deductible			х			х				х
Part B Excess						x 100%	x 80%		x 100%	x 100%
Foreign Travel										
Emergency			x	х	х	х	х	х	х	х
At-Home Recovery				Х			Х		х	х

Preventive Care not						
covered by Medicare			х			х

[COMPANY NAME]

Outline of Medicare Supplement Coverage - Cover Page 2 Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

	K**	L**
Basic Benefits	100% of Part A	100% of Part A
	hospitalization	hospitalization
	coinsurance plus	coinsurance plus
	coverage for 365 days	coverage for 365 days
	after Medicare	after Medicare
	benefits end	benefits end
	50% Hospice cost-	75% Hospice cost-
	sharing	sharing
	50% of Medicare-	75% of Medicare-
	eligible	eligible
	expenses for the	expenses for the
	first three pints	first three pints
	of blood	of blood
	50% Part B	75% Part B
	coinsurance, except	coinsurance, except
	100% coinsurance for	100% coinsurance for
	Part B preventive	Part B preventive
	services	services
Skilled Nursing	50% skilled nursing	75% skilled nursing
Coinsurance	facility coinsurance	facility coinsurance
Part A Deductible	50% Part A deductible	75% Part A deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel		
Emergency		
At-Home Recovery		
Preventive Care not		
covered by Medicare		
	\$4,000 out of pocket	\$2,000 out of pocket
	Annual Limit***	Annual Limit***

^{*}Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year (\$1,790) deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed (\$1,790). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

We (insert insurer's name) can only raise your premium if we raise the premium for all policies like yours

Rendered Wednesday, January 14, 2009

Page 2

Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change).

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert insurer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do not cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with medicare.

[For direct response issued policies]

(Insert insurer's name) is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local social security office or consult "the medicare handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan offered by the insurer a chart showing the services, medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts pursuant to section 3809(1)(k). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner. The insurer issuing the policy shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			100 1111
Semiprivate room and			
board, general nursing			
and miscellaneous services and supplies			
± ±	-11 1 . +050	1,0	4050/5
First 60 days	All but \$952	\$0	\$952(Part A Deductible)
61st thru 90th day	All but \$238	\$238	\$0
-	a day	a day	
91st day and after: -While using 60			
lifetime reserve days	All but \$476	\$476	\$0
	a day	a day	
<pre>-Once lifetime reserve days are used:</pre>			
-Additional 365 days	\$0	100% of Medicare	\$0

Rendered Wednesday, January 14, 2009

Page 3 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

		Eligible Expenses	
-Beyond the		Expenses	
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY	၃0 	Ş U	AII COSES
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the	2		
hospital			
First 20 days	All approved		
	amounts	\$0	\$0
21st thru 100th day	All but \$119	\$0	Up to \$119
	a day		a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your	All but very	\$0	Balance
doctor certifies you are	limited		
terminally ill and you	coinsurance		
elect to receive these	for outpatient		
services	drugs and		
	inpatient		
	respite care		

PLAN A

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE	PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-				
In or out of the hospital				
and outpatient hospital				
treatment, such as				
Physician's services,				
inpatient and outpatient				
medical and surgical				
services and supplies,				
physical and speech				
therapy, diagnostic tests, durable medical				
equipment,				
First \$124 of Medicare				
Approved Amounts*	\$0		\$0	\$124 (Part B Deductible)
Remainder of Medicare				
Approved Amounts	80%		20%	\$0
Part B Excess Charges				
(Above Medicare				
Approved Amounts)	\$0		\$0	All Costs
BLOOD				
First 3 pints	\$0		All Costs	\$0
Next \$124 of Medicare				
Approved Amounts*	\$0		\$0	\$124 (Part B Deductible)

Rendered Wednesday, January 14, 2009

Page 4 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—			
Tests for			
diagnostic services	100%	\$0	\$0
	PARTS A & B		
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
-Durable medical			
equipment			
First \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124 (Part B
			Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952	\$0
		(Part A	
		Deductible)	
61st thru 90th day	All but \$238	\$238	\$0
	a day	a day	
91st day and after			
-While using 60		4.5.6	
lifetime reserve days	All but \$476	\$476	\$0
-Once lifetime reserve	a day	a day	
days are used: —Additional 365 days	\$0	100% of	\$0
-Additional 303 days	٦٥	Medicare	
		Eligible	
		Expenses	
-Beyond the		Lingelibeb	
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
First 20 days	All approved		
01 100-1	amounts	\$0	\$0
21st thru 100th day	All but \$119	\$0	Up to \$119

Rendered Wednesday, January 14, 2009

Page 5

Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

	a day		a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
doctor certifies you are	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

MEDICARE PAYS

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

PLAN PAYS

YOU PAY

MEDICAL EXPENSES-In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$124 of Medicare Approved Amounts* \$0 \$0 \$124 (Part B Deductible) Remainder of Medicare Approved Amounts 80% 20% \$0 Part B Excess Charges (Above Medicare \$0 \$0 Approved Amounts) All Costs BLOOD \$0 First 3 pints \$0 All Costs Next \$124 of Medicare Approved Amounts* \$0 \$0 \$124 (Part B Deductible) Remainder of Medicare Approved Amounts 80% 20% CLINICAL LABORATORY

PARTS A & B					
HOME HEALTH CARE					
Medicare Approved					
Services					
-Medically necessary					
skilled care services					
and medical supplies	100%	\$0	\$0		
<pre>-Durable medical</pre>					
equipment					
First \$124 of					
Medicare					

\$0

100%

Rendered Wednesday, January 14, 2009

diagnostic services

SERVICES-Tests for

SERVICES

Page 6 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

\$0

Approved Amounts*	\$0	\$0	\$124 (Part B
			Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row

have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.					
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY		
HOSPITALIZATION*					
Semiprivate room and					
board, general nursing					
and miscellaneous					
services and supplies					
First 60 days	All but \$952	\$952	\$0		
-	i ·	(Part A	<u>'</u>		
		Deductible)			
61st thru 90th day	All but \$238	\$238	\$0		
	a day	a day			
91st day and after		1			
-While using 60					
lifetime reserve days	All but \$476	\$476	\$0		
1110010 1020110 0072	a day	a day			
-Once lifetime reserve					
days are used:					
-Additional 365 days	\$0	100% of	\$0		
maderenar see aars		Medicare			
		Eligible			
		Expenses			
-Beyond the					
Additional 365 days	\$0	\$0	All Costs		
SKILLED NURSING FACILITY	7 -				
CARE*					
You must meet Medicare's					
requirements, including					
having been in a hospital					
for at least 3 days and					
entered a Medicare-					
approved facility within					
30 days after leaving the					
hospital					
First 20 days	All approved				
11120 10 0072	amounts	\$0	\$0		
21st thru 100th day	All but \$119	Up to \$119	\$0		
2220 01124 200011 4447	a day	a day			
101st day and after	\$0	\$0	All costs		
BLOOD	7 -	1			
First 3 pints	\$0	3 pints	\$0		
Additional amounts	100%	\$0	\$0		
HOSPICE CARE		'	<u>'</u>		
Available as long as your	All but very	\$0	 Balance		
doctor certifies you are	limited	T ~			
terminally ill and you	coinsurance				
elect to receive these	for outpatient				
services	drugs and				
DCT VICCD	inpatient				
	respite care				
	DIAN C	<u> </u>	<u> </u>		

PLAN C

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted

with an asterisk)	vour Part B Dedu	ctible will have been	met for the calendar ye	ar
with an asterist,	your rait b boat	ictible will have been	i ilici ioi tiic caicilaai yt	·ui.

with an asterisk), your Part B Deductibl			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
In or out of the hospital			
and outpatient hospital			
treatment, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic			
tests, durable medical			
equipment,			
First \$124 of Medicare			
Approved Amounts*	\$0	\$124	\$0
		(Part B	
		Deductible)	
Remainder of Medicare		<u> </u>	
Approved Amounts	80%	20%	\$0
Part B Excess Charges			
(Above Medicare		İ	
Approved Amounts)	\$0	\$0	All Costs
BLOOD		1	
First 3 pints	\$0	All Costs	\$0
Next \$124 of Medicare	ľ		ľ
Approved Amounts*	\$0	\$124	\$0
		(Part B	
		Deductible)	
Remainder of Medicare		,	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			<u>'</u>
SERVICES-			
Tests for			
diagnostic services	100%	\$0	\$0
	PARTS A & B		ļ.'
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
-Durable medical		1	
equipment			
First \$124 of Medicare			
Approved Amounts*	\$0	\$124	\$0
		(Part B	
		Deductible)	
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
	S-NOT COVERED BY M		
FOREIGN TRAVEL-	1	1	
Not covered by Medicare			
Medically necessary	1		
emergency care services	1		
beginning during the			
first 60 days of each			
trip outside the USA			
First \$250 each	1		
calendar year	\$0	\$0	\$250
carcinat year	I~ J	1~ ∨	17450
Rendered Wednesday January 14, 2009	•	•	e Through PA 331-358 360

Rendered Wednesday, January 14, 2009

Page 8 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

Remainder of charges	\$0	80% to a	20% and
		lifetime	amounts
		maximum	over the
		benefit	\$50,000
		of \$50,000	lifetime
			maximum

PLAN D

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*	MEDICARE TAIS	I DAN TAID	100 TAI
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952	\$0
		(Part A	1
		Deductible)	
61st thru 90th day	All but \$238	\$238	\$0
	a day	a day	
91st day and after			
-While using 60			
lifetime reserve days	All but \$476	\$476	\$0
	a day	a day	
-Once lifetime reserve		1	
days are used:			
-Additional 365 days	\$0	100% of	\$0
		Medicare	
		Eligible	
		Expenses	
-Beyond the		1	
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY	ľ		
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
First 20 days	All approved		
11120 10 44,2	amounts	\$0	\$0
21st thru 100th day	All but \$119	Up to \$119	\$0
	a day	a day	
101st day and after	\$0	\$0	All costs
BLOOD	1	, -	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE		i ·	i i
Available as long as your	All but very	\$0	Balance
doctor certifies you are	limited	7	
terminally ill and you	coinsurance		
elect to receive these	for outpatient		
services	drugs and		
DCT ATCED	inpatient		
	respite care		
	PLAN D	<u> </u>	1

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

with an asterisk), your Part B Deductib	e will have been met for the	e calendar year.	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
In or out of the hospital			
and outpatient hospital			
treatment, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic			
tests, durable medical			
equipment,			
First \$124 of Medicare	1		
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare			1
Approved Amounts	80%	20%	\$0
Part B Excess Charges			
(Above Medicare			
Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
	-		(Part B
			Deductible)
Remainder of Medicare			Deducer Die
Approved Amounts	80%	20%	\$0
	80%	20%	70
CLINICAL LABORATORY			
SERVICES—			
Tests for	1,000		
diagnostic services	100%	\$0	\$0
	PARTS A & B	1	
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
-Durable medical			
equipment			
First \$124 of Medicare			İ
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY		200	
	1		1
SERVICES—			
Not covered by Medicare			
Home care certified by			
your doctor, for personal			
care during recovery from	I	I	I
an injury or sickness for			

-Number of visits covered (must be	\$0	Actual Charges to \$40 a visit E	Balance
received within 8 weeks of last			
Medicare Approved visit)	\$0	Up to the	
VISIC)	Ş U	number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	
OTHER BENEFITS-	NOT COVERED BY MEI	DICARE	
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a	\$250 20% and
	DIAN E	lifetime maximum benefit of \$50,000	amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952	\$0
		(Part A	
		Deductible)	
61st thru 90th day	All but \$238	\$238	\$0
	a day	a day	
91st day and after			
-While using 60			
lifetime reserve days	All but \$476	\$476	\$0
2 1 5 1 1	a day	a day	
-Once lifetime reserve			
days are used:	40	1000 - 5	40
-Additional 365 days	\$0	100% of Medicare	\$0
		Eliqible	
		1 ~	
-Beyond the		Expenses	
Additional 365 days	\$0	\$0	All Costs
Additional 303 days	140	<u> ۲ </u>	MII COSCS

CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$119 a day \$0	\$0 Up to \$119 a day \$0	\$0 \$0
BLOOD	7 0	7 0	1111 00505
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are	All but very	\$0	Balance
terminally ill and you	coinsurance		
elect to receive these	for outpatient		
services	drugs and		
	inpatient respite care		
	Leppice care		<u></u>

PLAN E

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—	MEDICARE PAIS	PLAN PAIS	100 PA1
In or out of the hospital			
and outpatient hospital			
treatment, such as Physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic			
tests, durable medical			
equipment,			
First \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare			,
Approved Amounts	80%	20%	\$0
Part B Excess Charges			
(Above Medicare		İ	
Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0

SERVICES— Tests for diagnostic services 100% \$0 \$0	CLINICAL LABORATORY	I	ı	I
Tests for diagnostic services				
Document Document				
HOME HEALTH CARE Medicare Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$124 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts OTHER BENEFITS—NOT COVERED BY MEDICARE FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first \$0 days of each trip outside the USA First \$250 each calendar year Remainder of Charges PARTS A & B HOME HEALTH CARE BOWN SO \$0 \$124 (Part B Deductible) **SO OTHER BENEFITS—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges \$0 \$0 \$0 \$250 Bown to a 1 ifetime maximum over the benefit benefit penefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered		100%	s 0	\$0
HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services and medical suppliesDurable medical equipment First \$124 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts OTHER BENEFITS—NOT COVERED BY MEDICARE FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Medically necessary emergency care services beginning during the first \$0 days of each trip outside the USA First \$250 each calendar year Remainder of Charges \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered			<u> </u>	<u></u>
Medicare Approved Services	HOME HEATTH CARE	TAKIB A & B		T
Services -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$124 of Medicare Approved Amounts* \$0 \$0 \$124 (Part B Deductible) Remainder of Medicare Approved Amounts 80% 20% \$0 OTHER BENEFITS—NOT COVERED BY MEDICARE FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year \$0 \$0 \$0% to a 20% and lifetime amounts over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
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Remainder of Medicare Approved Amounts OTHER BENEFITS—NOT COVERED BY MEDICARE FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered	rippi oved rimodires	,		I.
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OTHER BENEFITS—NOT COVERED BY MEDICARE FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered		80%	20%	\$0
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year \$0 \$0 \$0 \$250 Remainder of Charges \$0 \$0 \$0 \$0 \$and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				<u></u>
Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year \$0 \$0 \$0 \$250 Remainder of Charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered		T T T T T T T T T T T T T T T T T T T	ICARE	
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges \$0 \$0 \$250 Remainder of Charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year \$0 \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered print (100 days of each trip outside the USA \$0 \$0 \$0 \$250 80% to a 20% and lifetime amounts over the benefit \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
first 60 days of each trip outside the USA First \$250 each calendar year \$0 \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
trip outside the USA First \$250 each calendar year \$0 \$0 \$0 \$250 Remainder of Charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
First \$250 each calendar year Remainder of Charges \$0 \$0 \$80% to a 20% and lifetime amounts over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
calendar year Remainder of Charges \$0 \$0 \$0% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered	-			
Remainder of Charges \$0 80% to a lifetime amounts over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered		\$0	\$0	\$250
lifetime maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered		l'	1' '	I.
maximum over the benefit \$50,000 of \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered	remainaer of enargeb			
benefit \$50,000 lifetime maximum PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				1'
PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered			02 430,000	
BENEFIT— Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered	PREVENTIVE MEDICAL CARE		1	
Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
Annual physical and preventive tests and services administered or ordered by your doctor when not covered				
preventive tests and services administered or ordered by your doctor when not covered				
services administered or ordered by your doctor when not covered	preventive tests and			
or ordered by your doctor when not covered	-			
or ordered by your doctor when not covered				
doctor when not covered				
by Medicare I I I	by Medicare			
First \$120 each	4			
calendar year \$0 \$120 \$0		\$0	\$120	\$0
Additional charges \$0 \$0 All Costs		1.	\$0	All Costs

PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as plan F after you have paid a calendar year (\$1,790) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

nergency academore.			
SERVICES	MEDICARE	AFTER YOU	IN ADDITION
	PAYS	PAY \$1,790	TO \$1,790
		DEDUCTIBLE**,	DEDUCTIBLE**,

Rendered Wednesday, January 14, 2009

Page 13 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

	I	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952 (Part A Deductible)	\$0
61st thru 90th day	All but \$238 a day	\$238 a day	\$0
91st day and after —While using 60			
	All but \$476 a day	\$476 a day	\$0
<pre>-Once lifetime reserve days are used:</pre>			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	 \$0	 \$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved		
21st thru 100th day	amounts All but \$119 a day	\$0 Up to \$119 a day	\$0 \$0
101st day and after	\$0	\$0	All costs
BLOOD	1	<u></u>	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient	\$0	Balance
	respite care		
	PLAN F	ı	<u> </u>

PLAN F

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

^{*}Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

^{**}This high deductible plan pays the same benefits as plan F after you have paid a calendar year (\$1,790) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES		DICARE		ER YOU		N ADDITION
	:	PAYS		\$1,790		0 \$1,790
			1	CTIBLE**,		DUCTIBLE**,
MEDICAL EVDENCEC				AN PAYS	┢	YOU PAY
MEDICAL EXPENSES— In or out of the						
hospital						
and outpatient hospital						
treatment, such as	İ					
Physician's services,	İ		İ		İ	
inpatient and						
outpatient						
medical and surgical						
services and supplies, physical and speech						
therapy, diagnostic						
tests, durable medical	l					
equipment,	İ				İ	
First \$124 of						
Medicare	l					
Approved Amounts*	\$0		\$124		\$0	
			(Par	t в ctible)		
Remainder of Medicare			Dedu	ctible)		
Approved Amounts	80%		20%		\$0	
Part B Excess Charges					"	
(Above Medicare	İ		İ			
Approved Amounts)	\$0		100%		\$0	
BLOOD					Ī	
First 3 pints	\$0		All (Costs	\$0	
Next \$124 of Medicare	٦		4104		١	
Approved Amounts*	\$0		\$124 (Par		\$0	
			,	ctible)		
Remainder of Medicare				0012107		
Approved Amounts	80%		20%		\$0	
CLINICAL LABORATORY						
SERVICES-						
Tests for	1 0 0	•			١	
diagnostic services	100		\$0		\$0	
LIOME HEAT BUT CADE		PARTS A & B		<u> </u>		
HOME HEALTH CARE Medicare Approved						
Services						
-Medically necessary						
skilled care service						
and medical supplies		100%		\$0		\$0
-Durable medical						
equipment First \$124 of Medica	70.0					
Approved Amounts*		\$0		\$124		\$0
Approved Amounts				(Part B		
				Deductible)		
Remainder of Medicar	е					
Approved Amounts		80%		20%		\$0
	FITS	S-NOT COVERED	BY MI	EDICARE		
FOREIGN TRAVEL—						
Not covered by Medicare Medically necessary						
emergency care services						
concluding care pervices		1		1		ı

beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a	\$250 20% and
Remainder of Charges	50	lifetime	amounts over the
		benefit of \$50,000	\$50,000 lifetime maximum

PLAN G

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

nave been out of the nospital and have i		, <u> </u>	T - T
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952	\$0
		(Part A	
		Deductible)	
61st thru 90th day	All but \$238	\$238	\$0
-	a day	a day	ľ
91st day and after	1	1	
-While using 60			
lifetime reserve days	All but \$476	\$476	\$0
-	a day	a day	ľ
-Once lifetime reserve			
days are used:			
-Additional 365 days	\$0	100% of	\$0
	'	Medicare	
		Eligible	
		Expenses	
-Beyond the			
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY	1	, -	
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
First 20 days	All approved		
11150 20 44,5	amounts	\$0	\$0
21st thru 100th day	All but \$119	Up to \$119	\$0
ciii a aay	a day	a day	-
101st day and after	\$0	\$0	All costs
BLOOD	T -	T ~	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	1 - 0 - 0	γ ·	Y 0
	All but more	\$0	Palango
Available as long as your doctor certifies you are	All but very limited	PO	Balance
terminally ill and you	coinsurance	I	I

Rendered Wednesday, January 14, 2009

Page 16 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

elect to receive these	for outpatient	
services	drugs and	
	inpatient	
	respite care	

PLAN G

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

with an asterisk), your Part B Deductible		_	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
In or out of the hospital			
and outpatient hospital			
treatment, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical	İ		
services and supplies,	İ		
physical and speech	İ		
therapy, diagnostic			
tests, durable medical			
equipment,			
First \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
rippioved randaries	~ ~	7 0	(Part B
			Deductible)
Remainder of Medicare			Deducerbie,
Approved Amounts	80%	20%	\$0
Part B Excess Charges		200	
(Above Medicare			
Approved Amounts)	\$0	80%	20%
BLOOD	\$ U	00%	200
First 3 pints	ė o	All Costs	\$0
Next \$124 of Medicare	\$0	AII COSES	ŞU
•	ė o	\$0	\$124
Approved Amounts*	\$0	Ş U	I'
			(Part B
Daniela de Madiness			Deductible)
Remainder of Medicare	0.0%	000	d O
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—			
Tests for			
diagnostic services	100%	\$0	\$0
	PARTS A & B		
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
—Durable medical			
equipment			
First \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare			
	80%	20%	\$0
AT-HOME RECOVERY			<u> </u>
SERVICES—			
Not covered by Medicare			
2			

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved			
visit)	\$0	Up to the number of	
		Medicare	
		Approved	
		visits, not to exceed 7	
		each week	
-Calendar year maximum	\$0	\$1,600	
OTHER BENEFITS-	NOT COVERED BY MEI	DICARE	
FOREIGN TRAVEL—			
Not covered by Medicare			
Medically necessary			
emergency care services			
beginning during the			
first 60 days of each trip outside the USA			
First \$250 each			
calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a	20% and
		lifetime	amounts
		maximum	over the
		benefit of \$50,000	\$50,000 lifetime
		OT \$20,000	maximum
	PI,AN H	ļ	JG.I.I.IIIGIII

PLAN H

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but \$952	\$952	\$0
		(Part A	
		Deductible)	
61st thru 90th day	All but \$238	\$238	\$0
	a day	a day	
91st day and after			
-While using 60			
lifetime reserve days	All but \$476	\$476	\$0
	a day	a day	
-Once lifetime reserve			
days are used:			1.
-Additional 365 days	 \$0	100% of	 \$0

Rendered Wednesday, January 14, 2009

Page 18 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

		Medicare Eligible	
Darrand the		Expenses	
-Beyond the	Ġ O	\$0	711 0000
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
First 20 days	All approved	d O	d O
21-t th 100th da	amounts	\$0	\$0
21st thru 100th day	All but \$119	Up to \$119	\$0
101st day and after	a day \$0	a day \$0	All costs
BLOOD	\$0	Ş U	AII COSES
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	100%	γo	γ 0
Available as long as your	All but very	\$0	Balance
doctor certifies you are	limited	٦	Daranec
terminally ill and you	coinsurance		
elect to receive these	for outpatient		
services	drugs and		
	inpatient		
	1 -		

PLAN H

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

with an asterisk), your rait b beduction	will have been flict for the	caiciidai year.	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
In or out of the hospital			
and outpatient hospital			
treatment, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical services and supplies,			
physical and speech			
therapy, diagnostic			
tests, durable medical			
equipment,			
First \$124 of Medicare			
Approved Amounts*	\$0	\$0	\$124
			(Part B
			Deductible)
Remainder of Medicare	0.00	0.00	40
Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare			
Approved Amounts)	\$0	\$0	All Costs
BLOOD	30	Ş 0	AII COSCS
First 3 pints	\$0	All Costs	\$0
Next \$124 of Medicare			7
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Rendered Wednesday, January 14, 2009

Page 19 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

Approved Amounts*	\$0	\$0	\$124 (Part B Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—			
Tests for diagnostic services	100%	\$0	\$0
diagnostic services	PARTS A & B	ာ	Ş0
HOME HEALTH CARE	I WANTS A & B	ı	1
Medicare Approved Services -Medically necessary skilled care services			
and medical supplies -Durable medical equipment First \$124 of Medicare	100%	\$0	\$0
Approved Amounts*	\$0	\$0	\$124 (Part B Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
OTHER BENEFITS	S-NOT COVERED BY ME	EDICARE	
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit	\$250 20% and amounts over the \$50,000
		of \$50,000	lifetime maximum

PLAN I

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.					
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY		
HOSPITALIZATION*					
Semiprivate room and					
board, general nursing					
and miscellaneous					
services and supplies					
First 60 days	All but \$952	1'	\$0		
		(Part A			
		Deductible)			
61st thru 90th day	· '	\$238	\$0		
	a day	a day			
91st day and after					
-While using 60	777 1 4 400	4.7.6	4.0		
lifetime reserve days	· '	\$476	\$0		
	a day	a day			
-Once lifetime reserve		l			

Rendered Wednesday, January 14, 2009

Page 20 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

days are used: -Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the			
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital			
First 20 days	All approved		
21st thru 100th day	amounts All but \$119 a day	\$0 Up to \$119 a day	\$0 \$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN I

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE	PAYS	PLAN P.	AYS	YOU PAY
MEDICAL EXPENSES-					
In or out of the hospital					
and outpatient hospital					
treatment, such as					
Physician's services,					
inpatient and outpatient					
medical and surgical					
services and supplies,					
physical and speech					
therapy, diagnostic					
tests, durable medical					
equipment, First \$124 of Medicare					
Approved Amounts*	\$0		\$0		\$124
Approved Amounts"	٦٥		Ş U		۶۱۷۹ (Part B
					Deductible)
Remainder of Medicare					Dedde cibie,
Approved Amounts	80%		20%		\$0
Part B Excess Charges					-
(Above Medicare					
Approved Amounts)	\$0		100%		\$0
BLOOD	1				

First 3 pints Next \$124 of Medicare	\$0	All Costs	\$0
Approved Amounts*	\$0	\$0	\$124 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— Tests for		200	,
diagnostic services	100%	\$0	\$0
	PARTS A & B		
HOME HEALTH CARE Medicare Approved Services -Medically necessary skilled care services			
and medical supplies -Durable medical equipment First \$124 of Medicare	100%	\$0	\$0
Approved Amounts* Remainder of Medicare	\$0	\$0	\$124 (Part B Deductible)
Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit -Number of visits covered (must be received within 8 weeks of last Medicare Approved	\$0	Actual Charges to \$40 a visit	Balance
visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	
	NOT COVERED BY MED:	ICARE	
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each			

calendar year	\$0	\$0	\$250
Remainder of Charges*	\$0	80% to a	20% and
		lifetime	amounts
		maximum	over the
		benefit	\$50,000
		of \$50,000	lifetime
			maximum

PLAN J OR HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

**This high deductible plan pays the same benefits as plan J after you have paid a calendar year (\$1,790) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are \$1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's outpatient prescription drug deductible or separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU	IN ADDITION
		PAY \$1,790	TO \$1,790
		DEDUCTIBLE**,	DEDUCTIBLE**,
		PLAN PAYS	YOU PAY
HOSPITALIZATION*			1 100 1111
Semiprivate room and			
board, general			
nursing			
and miscellaneous			
services and supplies		4050	40
First 60 days	All but \$952	\$952	\$0
		(Part A	
55		Deductible)	1.0
61st thru 90th day		\$238	\$0
	a day	a day	
91st day and after			
-While using 60			
lifetime reserve			
days	All but \$476	\$476	\$0
	a day	a day	
-Once lifetime			
reserve			
days are used:			
-Additional 365			
days	\$0	100% of	\$0***
		Medicare	
		Eligible	
		Expenses	
-Beyond the		-	
Additional 365			
days	\$0	\$0	All Costs
SKILLED NURSING	ĺ	ĺ	
FACILITY			
CARE*			
You must meet			
Medicare's			
requirements,			
including			
having been in a			
hospital			
for at least 3 days			
and			
entered a Medicare-			
entered a Medicare-	I	I	I

^{*}A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

approved facility within			
30 days after leaving			
the			
hospital			
First 20 days	All approved		
	amounts	\$0	\$0
21st thru 100th day	All but \$119	Up to \$119	\$0
	a day	a day	
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount medicare would have paid for up to an additinal 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN J

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

*Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as plan J after you have paid a calendar year (\$1,790) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are \$1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate outpatient prescription drug deductible or foreign travel emergency deductible.

	PAY \$1,790	IN ADDITION TO \$1,790 DEDUCTIBLE**, YOU PAY
All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
\$0	l ·	\$0
	(Part B Deductible)	
	All but very limited coinsurance for outpatient drugs and inpatient respite care	PAY \$1,790 DEDUCTIBLE**, PLAN PAYS All but very \$0 limited coinsurance for outpatient drugs and inpatient respite care

Rendered Wednesday, January 14, 2009

Page 24 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

Remainder of					
Medicare					
Approved Amounts	80%		20%		\$0
Part B Excess					
Charges (Above Medicare					
Approved Amounts)	\$0		100	2	\$0
BLOOD	70		100	.0	70
First 3 pints	\$0		All	Costs	\$0
Next \$124 of Medicare	, ,		[00202	
Approved Amounts*	\$0		\$12	4	\$0
			(Pa	rt B	
			Ded	uctible)	
Remainder of Medicare	l				
Approved Amounts	80%		20%		\$0
CLINICAL LABORATORY					
SERVICES—					
Tests for diagnostic services	 100%		\$0		\$0
diagnostic services	100%	PARTS A & B			β·0
HOME HEALTH CARE		T T T T T T T T T T T T T T T T T T T		1	
Medicare Approved					
Services					
-Medically necessary					
skilled care servic					
and medical supplie	S	100%		\$0	\$0
-Durable medical					
equipment					
First \$124 of Medic Approved Amounts*	are	\$0		\$124	\$0
Approved Amounts		\$ U		(Part B	٥٠
				Deductible)	
Remainder of Medica	re				
Approved Amounts		80%		20%	\$0
AT-HOME RECOVERY					
SERVICES-					
Not covered by Medicar					
Home care certified by					
your doctor, for perso	nal				
care beginning during					
recovery from an injur or sickness for which	У				
Medicare approved a					
Home Care Treatment Pl	an				
-Benefit for each vi		\$0		Actual	
				Charges to	
		İ		\$40 a visit	Balance
-Number of visits					
covered (must be					
received within 8					
weeks of last		d 0		77	
Medicare Approved vi	SIT)	\$0		Up to the number of	
				Medicare	
				Approved	
				visits, not	
				to exceed 7	
				each week	
Calendar year maxim	um	\$0		\$1,600	
Отнго вем	r r T T T	S-NOT COVERE	D BV M	IEDICADE	

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges		\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT- Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0	\$120	\$0
	\$0	\$0	All costs

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds¹ in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$952	\$476 (50% of Part A Deducti- ble)	\$476 (50% of Part A Deductible) ¹
61st thru 90th day 91st day and after: -While using 60	All but \$238 a day	\$238 a day	\$0
lifetime reserve days -Once lifetime reserve days are used:	All but \$476 a day	\$476 a day	\$0
-Additional 365 days	\$0	100% of Medicare	\$0***

Rendered Wednesday, January 14, 2009

Page 26 Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

		Eligible	
		Expenses	
-Beyond the		_	
	\$0	\$0	All Costs
SKILLED NURSING FACILITY			
CARE**			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital	All approximated		
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but	Up to	Up to
2	\$119 a	\$59.50	\$59.50
	day	a day	a day 1
101st day and after	\$0	\$0	All costs
BLOOD	7 -	7 -	
First 3 pints	\$0	50%	50% ¹
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your	Generally,	50% of	50% of
	most Medicare	coinsur-	coinsur-
	eligible	ance or	ance or
elect to receive these	expenses for	copayments	copayments 1
services	outpatient		
	drugs and		
	inpatient		
	respite care		

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

****Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PA	AYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$124 of Medicare				
·	\$0	S	\$0	\$124 (Part B Deductible) **** ¹
Preventive Benefits for Medicare covered services	Generally 7 or more of Medicare ap		Remainder of Medi- care	All costs above Medi- care

Rendered Wednesday, January 14, 2009

Page 27

Michigan Compiled Laws Complete Through PA 331-358, 360, 361, 364-367, 370-378, 382, 384-386, 390-394, and 396-427, 429, and 431 of 2008

Remainder of Medicare Approved Amounts	proved amounts Generally 80%	approved amounts Generally 10%	approved amounts Generally 10% ¹
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out- of-pocket limit of \$4,000)*
BLOOD			
First 3 pints	\$0	50%	50% ¹
Next \$124 of Medicare			
Approved Amounts****	\$0	\$0	\$124 (Part B Deductible) **** ¹
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ¹
CLINICAL LABORATORY			
SERVICES-Tests for			
diagnostic services	100%	\$0	\$0

^{*}This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

	PARTS A & B		
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
-Durable medical			
equipment			
First \$124 of Medicare			
Approved Amounts****	\$0	\$0	\$124 (Part B
			Deductible) 1
Remainder of Medicare			
Approved Amounts	80%	10%	10% ¹

^{*****}Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds¹ in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and			
board, general nursing			

and miscellaneous services and supplies First 60 days	All but \$952	\$714 (75% of Part A Deducti-	\$238 (25% of Part A Deductible) ¹
61st thru 90th day	All but \$238 a day	ble) \$238 a day	\$0
91st day and after: -While using 60 lifetime reserve days	All but \$476 a day	\$476 a day	\$0
<pre>-Once lifetime reserve days are used:</pre>	a day	a day	
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0***
-Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after BLOOD	All approved amounts All but \$119 a day \$0	\$0 Up to \$89.25 a day \$0	\$0 Up to \$29.75 a day ¹ All costs
First 3 pints Additional amounts	\$0 100%	75% \$0	25% ¹ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsur- ance or copayments	25% of coinsurance or copay- ments ¹

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

****Once you have been billed \$124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

======================================				
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*	
MEDICAL EXPENSES-				
In or out of the hospital				

and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$124 of			
Medicare Approved Amounts****	\$0	\$0	\$124 (Part B Deducti- ble)**** ¹
Preventive Benefits for	Generally 75%	Remainder	All costs
Medicare covered	or more of	of Medi-	above Medi-
services	Medicare	care	care
	approved	approved	approved
Remainder of Medicare	amounts	amounts	amounts
Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare Approved Amounts)	φ. 	β 0	(and they do not count
Approved Amounts)			toward
			annual out-
			of-pocket
			limit of
			\$2,000)*
BLOOD			1
First 3 pints	\$0	75%	25% ¹
Next \$124 of Medicare			
Approved Amounts****	\$0	\$0	\$124
			(Part B
			Deductible) 1
Remainder of Medicare	Generally	Generally	Generally
Approved Amounts	80%	15%	5% ¹
CLINICAL LABORATORY			
SERVICES—Tests for	1.000		
diagnostic services	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

	PARTS A & B		
HOME HEALTH CARE			
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
-Durable medical			
equipment			
First \$124 of Medi-			
care Approved	\$0	\$0	\$124 (Part
Amounts			B Deducti-
			ble) ¹
Remainder of Medicare			_
Approved Amounts	80%	15%	5% ¹

Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People

with Medicare.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

 $\textbf{Compiler's note:} \ In \ the \ first \ sentence \ of \ the \ notice \ following \ the \ table \ entitled \ "PLAN \ J \ OR \ HIGH \ DEDUCTIBLE \ PLAN \ J," \ the \ word \ "additional" \ should \ evidently \ read \ "additional."$

¹In Plans K and L, a superscript numeral "1" has been substituted wherever a diamond symbol should occur.

Popular name: Act 218